Supplementary file 6: Sample evidence from papers supporting CMOCs

| CMOC | Supporting evidence | Additional considerations or caveat evidence |
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| CMOC 1: Understanding behaviour as communication to improve staffs' ability to respond | Banks (2014) [39]<br>One participant reported that use of the This is Me document had reduced the levels of medication prescribed and in turn the number of falls:<br>By having this document we have reduced the amount of medication the patient receives in hospital. Staff are much more likely to look into why the patient is behaving this way rather than get them prescribed medication. This in turn has reduced the number of falls during the day, therefore reducing the number of fractures and increased stays in hospital. (p727)<br><br>Galvin (2010) [10]<br>Participants were asked to rate their level of confidence in dealing with the hospitalized patient with dementia before and after the program. Participants reported a significant improvement in their overall confidence (Table | Spencer (2013) [55]<br>Standard care respondents felt that some staff displayed a negative attitude towards confused patients. Participants felt that staff had little understanding and limited training in dementia care, which carers felt resulted in patients being ignored, shouted at or threatened when staff were faced with uncooperative or challenging situations. In some cases, this led to a confrontation between nurses and family carers who reacted to what they perceived as unacceptable staff attitudes towards patients. These carers further highlighted that they had not formally reported for fear of repercussions towards their relatives:<br>She [health care assistant] kept shouting at him, turn over, turn over I can't get to you. So eventually I opened the curtains and said that man's confused he can't understand you. She [health care assistant] knew I was sitting |

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| | 2) as well as in each individual variable: assessment and recognition of dementia, managing dementia care, differentiating dementia from delirium, communicating with the patient and family and discharge planning. (p5)<br><br>Williams (2011) [51]<br>The carer's sheet asks about people's life history which can help staff talk to patients in a meaningful way, or distract or calm those who might be agitated. One woman had been a dance teacher so when she became agitated the nurses could talk about this or look at old photographs with her which helped to distract her. Another woman sometimes hit and kicked staff, but her son was able to tell us that this meant she was in pain, so again, we could respond accordingly. (p17) | outside the curtain and it didn't deter her, she was really shouting. (Wife of 69-year-old, male, standard care patient.) (p3)<br><br>Goldberg (2014) [45]<br>However, the psychological needs of the patients on the Unit were high and a minority of patients would call out persistently for long periods of time. Staff would try to comfort or distract them…. But the calling out would resume once the staff member left the patient and the conflicting demands on time meant staff would sometimes ignore their cries and attend to other patients, staff or documentation…. Delivering care to patients with these behaviours could be exhausting and sometimes, particularly towards the end of a 'long day' (12 1/2 h shift), staff would ignore patients. (p1338) |

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| CMOC 2: The role of experiential learning and creating empathy to encourage reflection for responsibilities of care | Baillie (2015) [47]<br>Barbara's Story engaged staff emotionally and prompted empathetic responses. They related to her as an individual and her experience. Staff related to Barbara as someone who could be their family member and for some staff, Barbara's experience mirrored their own family experiences. Staff expressed increased awareness of dementia and how it could be recognised, both within the Trust and outside. … Staff discussed how their own interactions with patients and behaviour had changed since watching Barbara's Story, and they often referred to changes they had observed in other staff too. Changes included:<br>giving more time to patients, improved communication, giving more information, and assisting patients who are looking lost. Staff also discussed how Barbara's Story had highlighted their professional responsibilities. (p28) | Baillie (2015) [47]<br>Time was a key constraint identified, along with the perception that 'people with dementia require a lot of your time' (Nurses8)…. Staff discussed the importance of having sufficient and high quality time for people with dementia (Nurses7, Nurses8) and the acknowledgement that time spent is of value:<br>Recognising that if you're spending one to one time with a person with dementia, whether it's walking around talking about where the boat goes from, that is valid. That's not, not doing work. (Nurses2) (p56)<br><br>Staff discussed how they put the Trust values into action. The value 'Patients first' had a strong resonance and there were many examples of going 'the extra mile' to benefit patients. Staff also discussed a perceived culture change within the Trust so that they felt able to spend longer with a patient or to challenge others about their practice. There |

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| | Duffin (2013) [53]<br>In one training session nurses, doctors and other staff wear specially designed goggles that restrict their vision, and put on a jacket which has small splints inserted in the arms to restrict movement of their upper body . This is to help staff understand the physical constraints faced by some older people. Darlene Romero, a matron across the trust's three older people's wards, who delivers the training, says: 'It's a real eye opener, and makes you realise how difficult it can be to go to the toilet.' (p16)<br><br>Williams (2011) [51]<br>REACH helps all staff to understand the cognitive difficulties experienced by people with dementia. It enables them to contribute in their role and promotes pride in the part they play in care. (p15) | was reference to standard setting and a new 'norm' having been established in the Trust. (p34)<br><br>Scerri (2015) [46]<br>Although family members appreciated that care is provided in time and when required, hospital staff felt that positive experiences with dementia patients can be achieved if they went the 'extra mile'; when they adopted initiatives or carried out actions that were not part of the normal care routine or that fall within their job description. (p6) |

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| CMOC 3: Clinical experts who legitimise priorities for care | Baldwin (2004) [62]<br>Liaison support comprised encouragement of person-centred care, education about mental disorder, nutrition and safety issues, and sign-posting to relevant services. Interventions were tailored to the patient and lasted for a maximum of 6 weeks. (p473)<br><br>Elliot (2011) [59]<br>As many ward doctors and nurses do not have adequate knowledge to address the needs of older patients who present with behaviour that challenges, part of the input from the DNS has focused on addressing this requirement, and this activity has assisted in reducing length of stay by discouraging inappropriate sedation, which generally contributes to poor patient outcomes. (p649)<br><br>Baillie (2015) [47]<br>Staff recognised that Barbara's Story had been developed within the context of the Trust | Goldberg (2014) [45]<br>Lisa walks down the walkway. The staff say ''Morning Lisa'' ''Morning'' as they walk past. . . Lisa says that this is a strange hospital. The auxiliary says ''If you want to go down that way with [the mental health nurse], she's lovely''. Lisa says ''You're all lovely''. The mental health nurse then talks to Lisa for some time. MMHU55. (p1339)<br><br>Ellison (2014) [40]<br>While Champions with different levels of seniority generally feel able to influence colleagues to some extent, challenging inappropriate attitudes and behaviour, implementing and embedding change within their own or other ward settings, and with other professional groups tends to be easier the more senior their position… "It's easier to address change with nurses if you're their manager" [SCN Champion - interviewee] (p34) |

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| | values and they discussed how they applied the values in action. There was recognition that each individual was representing the Trust and a sense of pride which prompted certain behaviours. There was also discussion about a culture change having taken place following on from Barbara's Story. Dementia was now seen as 'everybody's business' with a Trust-wide awareness. Staff discussed that Barbara's Story established standards expected within the Trust for patients generally and the expectation of improvement. It was also considered that Barbara's Story had established the role that all staff were expected to play in improving patients' experience, particularly for those who are most vulnerable. Barbara's Story had also set out an expectation for staff to be proactive about challenging care. (p60) | Nichols (2002) [41]<br>This change affected staff's job descriptions, the nature of their work, and what was considered important and not important… we did ask every member of the team… to sit down and think through how their jobs would be different if, in fact, they were responding to the needs of both the caregiver and the patient." (p187) |
| CMOC 4: Staff with confidence to adapt working practices and routines to individualise care | Edvardsson (2012) [50]<br>Sharing place and moment was characterised by staff actions such as: involving patients in | Rosler (2012) [54]<br>The CGU has additional components compared to conventional geriatric treatment: hidden exit |

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| | meaningful ways in tasks that had to be done; socially dining with patients; small talking with them in the day room; jointly performing different non-medicalised activities; or in other ways going beyond routines to make the content of the day mean a little extra for patients. The baseline activities at the ward consisted mostly of routine based medical tasks and the category sharing place and moment was observed when staff initiated different forms of leisure activities involving the patients. (p4)<br><br>Bray (2015) [48]<br>Bay nursing is a really positive move. I enjoy being more person focused, knowing what I am doing as a result of getting to know my patients better. Showers and baths can be offered more frequently and patients can have the time to do things more independently – that is, patients assisted to walk to the toilet as opposed to | doors, increased light in hallways and patient rooms, night lights, a treatment room on the wad to decrease patient transferral, a living and eating room, and a loop track for wandering patients. The number of beds was decreased from 28 (non-CGU ward) to 23 on the CGU. (p400)<br><br>Bray (2015) [48]<br>Bay nursing identifies one nurse as responsible for monitoring each bay for an entire shift, generally from 7.15am to 7.45pm, alongside a healthcare assistant. These two staff members have a maximum of seven patients under their care at any time. To achieve this, the 27-bed ward had two beds removed, one from a male bay and one from a female bay. The extra space was put to good use by introducing a communal table into each bay. (p22) |

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| | given a commode because of time pressures.' (p24)<br><br>Schneider (2010) [60]<br>Invoking their practical autonomy, the HCAs also made minor adaptations within routines to suit individual patients. For example, medications were administered to all patients at approximately the same times every day on each ward, rather than being doled out individually; this ensured that every patient received his or her medication, as well as conserving staff time. However, within this routine, HCAs who were 'running' the medications would often make small concessions, for example by taking extra time to gain the trust of individual patients. [p50}<br><br>Rosler (2012) [54]<br>In the CGU described here, physiotherapists and nurses tried to activate patients more individually by catching the right moment | |

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| | rather than working according to strict time schedules. However we cannot pin down the effect of a multidimensional intervention to a single factor. (p401) | |
| CMOC 5: Staff with responsibility to focus on psychosocial needs | Harwood (2010) [61]<br>The Occupational Therapist introduced occupational profiling using the Pool Activity Level instrument which was consistent with a person-centred care approach. This aims to identify the level of function for a patient on admission, and the development of care plans for personal care and other activities. As a result staff could engage patients in activities at a level where they could be successful, helping patients avoid the distressing experience of repeated failure. A health care assistant took specific responsibility for developing a programme of activities matched to ability using the occupational profile levels. She made contact with activities co-ordinators in the Mental Health Trust and kept a log of what she | Harwood (2010) [61]<br>What didn't work:<br>Activities co-ordinator not on duty every day; activities otherwise dependent on ward staffing levels. (p23)<br><br>Goldberg (2014) [45]<br>The staffing resources needed to keep patients safe could result in less time being available for other patients on the ward…. At times, activities coordinators and mental health nurses were allocated to watch the cohort bay, preventing their engagement in the organised activities and mental health assessments they were employed to provide. (p1338)<br><br>Bray (2015) [48] |

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| | had done. This included games (bowling, giant noughts and crosses, dominoes, ludo), quizzes, drawing and crafts, music, reminiscence, and exploration of senses. (p21)<br><br>Edvardsson (2012) [50]<br>The staff member involved all of the five patients in the day room in the activity, by talking to them interchangeably – each in a personalised way, asking for advice, comments and suggestions. It was a moment when she created a homely atmosphere through seeing, communicating and involving all persons present in the room at the same time. All of the patients present in the room expressed appreciation, interest and joy. (Field note no. 19, Friday 14.15, Day room) (p4)<br><br>Zieschang (2010) [52]<br>Daytime activities are conducted especially during the afternoon when staffing by the | Unfortunately, the ward has faced challenges because some of its staff have been moved to support other areas of the hospital, making it impossible to implement bay nursing at times because of inadequate staffing levels. This has been disheartening for staff that are unable to fulfil their new role, which they know has been effective. (p24)<br><br>Moyles (2011) [56]<br>The allocation of the special is ideally determined by the needs of the patient, yet in reality the allocation is more often determined by other constraints such as nurse shortages and budget constraints. However, it was clear that whatever the background of the special they generally did not have sufficient skills in how to care for a person with dementia. A MD expressed this as:<br>So they tend to call for a special, who will be someone who is extra, called in. Not necessarily a group of people who have experience in |

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| | nurses is reduced and the sun-downing phenomenon might occur. (p144) | aged care…it tends to be the most junior nursing staff with the least amount of education. (MD, P11) (p424) |
| CMOC 6: Building staff confidence to provide person-centred risk management | Zieschang (2010) [52]<br>Concern arose about promoting ambulation in a unit where patients are allowed to walk unassisted and where rejection of physical restraints might increase the number of falls and fall-related injuries especially fractures… Even though these events may happen, it is our estimation that the benefits of unrestricted ambulation outweigh the risks. Fall prevention interventions, such as review of medication, restrictive use of sedatives, adequate footwear and lighting are applied. (p143)<br><br>Nichols (2002) [41]<br>They [staff] observe that on this floor when patients in beds 6 through 21 get agitated, they can order restraints. But if patients in beds 22 through 30 become agitated, they are | Zieschang (2010) [52]<br>We promoted mobility on the unit among older and often frail patients with limited insight concerning their fall risk, the number of falls, especially injurious falls, appears to be an in important criterion to assess whether this concept of letting them wander at liberty is acceptable. (p141)<br><br>Bray (2015) [48]<br>The main challenge encountered when bay nursing was introduced was staff not understanding or appreciating that the bay could not be left unattended. It was reinforced to staff that if they left the bay the link with patients was lost and there was no one available to monitor patient safety or provide |

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| | supposed to go see the patient and find out why he or she is upset. (p186)<br><br>Luxford (2015) [57]<br>Surveys about the implementation process identified that the simplicity of theTOP5 process and strategies was considered by clinicians as the 'key to success'. Successful uptake relied on acceptability to staff and an existing culture of engagement with carers. Early in the implementation period, a few clinicians reported difficulty in translating the carers' tips into a workable strategy for the hospital environment as they lacked confidence to write strategies based on 'non-clinical' tips. This issue was addressed through further training and the development of lanyards for clinicians to use which demonstrated how to write an effective TOP 5. (p5) | assistance as required. Staff had therefore to ensure that appropriate cover was in place if they needed to leave the bay for any reason. As two members of staff are allocated to each bay, this was thought not to be overly restrictive, although it can become more challenging during longer shifts. (p23)<br><br>Galvin (2010) [10]<br>Hospital A instituted a "Code Green" procedure that placed patients at risk for elopement in green gowns and trained staff on appropriate dementia-friendly responses and precautions. (p10) |